NEW HAMPSHIRE MEDICAID

272E FFS i
10/2018

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

REQUEST FOR SERVICE AUTHORIZATION
IN EXCESS OF SERVICE LIMITS
NON THERAPY
(Fee-for-Service (FFS) Program Only –
Not for Managed Care program use)
Instructions for filling out this form are attached.

***PLEASE PRINT OR TYPE ALL INFORMATION (All fields are required) ***

RECIPIENT INFORMATION

RECIPIENT NAME: _____ DATE OF BIRTH:_____

RECIPIENT MEDICAID ID #: _____ DIAGNOSIS (NOT CODES) _____

ALTERNATE INSURANCE: NAME OF PLAN:

PROVIDER INFORMATION

DATE(S) OF SERVICE: _____ CONTACT PERSON: _____

TELEPHONE #: _____ FAX #:_____

PERFORMING PROVIDER: _____ PROVIDER MEDICAID ID #: _____

REQUESTING FACILITY: _____ REQUESTING FACILITY MEDICAID ID #:_____

TYPE OF TREATMENT	PROCEDURE CODE	FREQUENCY OF TREATMENT	TOTAL # OF UNITS	DATES OF SERVICE	
				START	END

ANTICIPATED RESULT(S) OF PROVIDING THESE EXTRA SERVICES: (use additional paper as necessary)

__CLINICAL INFORMATION__ required to be submitted with authorization form: Please attach physician's order and clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes, Goals and Objectives.

CERTIFICATION OF MEDICAL NECESSITY
(to be signed by the PCP or treating physician/APRN)

I certify that the requested treatments and/or therapies are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

_____ _____
Physician's Signature Date

_____ _____
Print Name/Title Specialty (if applicable)

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■Concord, NH 03301 ■FAX: (603) 271-8194

INSTRUCTIONS FOR REQUEST FOR SERVICE AUTHORIZATION IN EXCESS OF SERVICE LIMITS
FORM 272E FFS REQUEST FOR SERVICE AUTHORIZATION IN EXCESS OF LIMITS

Please note that before this form is filled out, it is **your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections of the form are the Recipient Information and Provider Information and should be filled out accordingly. Note that the Performing Provider is the provider providing the service and the Requesting Facility is the place where the service is provided. These two provider numbers must be different.

The next section is the service you are requesting. Fill in a description of the treatment, the Procedure Code, how often therapy will take place, the total number of units in excess of the units allowed without service authorization and the start end date of these extra units.

Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Fax all documentation and the SA form to 603-271-8194. You will receive a fax from the State with the approval information or a request for more information.

Once the SA has been approved by the State it is sent to the Fiscal Agent, Conduent, to create the authorization. Conduent has three business days to create and mail the authorization to the performing provider. If you have questions, please call Conduent at 1-866-291-1674.